Process of Performance Indicator Development for the Mental Health Services Act

Promoting Accountability and Quality Improvement for Services to Consumers

Presented by

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Performance Outcomes & Quality Improvement
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Process of Performance Indicator Development for the Mental Health Services Act

Influential Factors and Contributors:

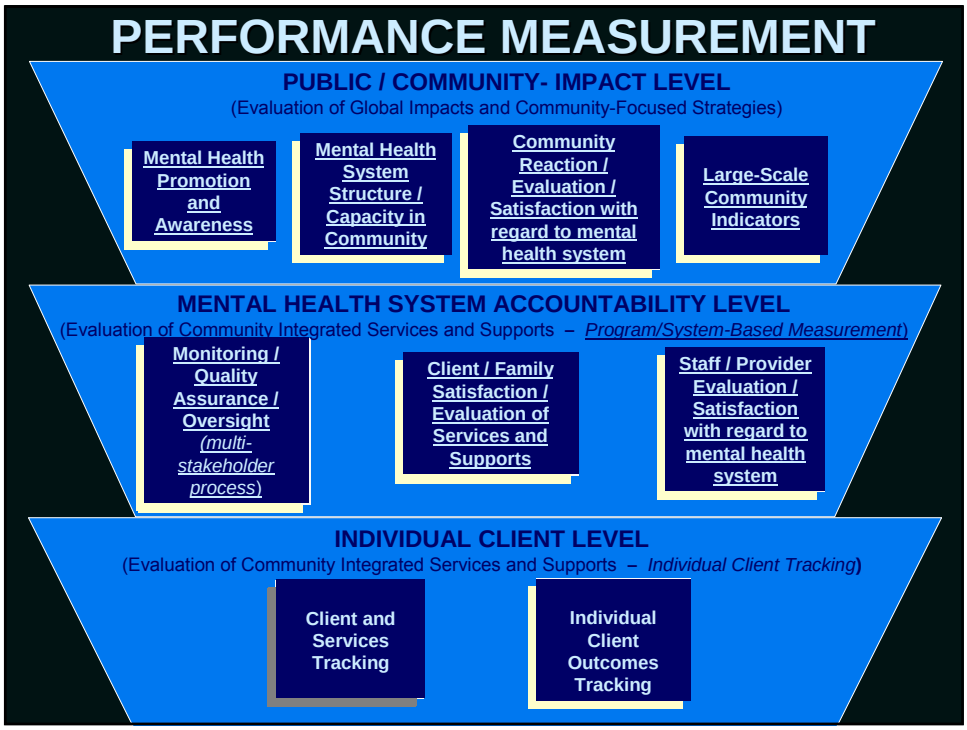
- Performance Measurement Paradigm
- Accountability/Responsibility and Quality Improvement Philosophies
- Large stakeholder process/input & previous legislation
- AB 2034 as one Model
- Performance Measurement Advisory Committee (PMAC)
- Appropriate Evaluation Methods
- Input from MHSOAC, CMHDA, CMHPC, SQIC, ESMs, etc.
- Federal Requirements – (Block Grant, URS/DIG, NOMS)
- Services/Strategies Tracking: CSI Data Collection / Cost Reporting & Expenditure Accounting, Oversight and Fidelity Monitoring
- Supporting Information Technology Infrastructure / IT Workgroup

Initial Evaluation of MHSA Full Service Partnership Clients

Process of Performance Indicator Development for the Mental Health Services Act

Influential Factors and Contributors

- Performance Measurement Paradigm



PERFORMANCE MEASUREMENT

INDIVIDUAL CLIENT LEVEL

(Evaluation of Community Integrated Services and Supports – *Individual Client Tracking*)

Client and Services Tracking *(Examples)*

- Client-specific information, e.g., contact, demographic information, reason for system disengagement, etc.
- Services / supports information, e.g., new services/programs/supports pertinent to the MHSA, evidence-based practices, levels of care, partnering agency/provider services, etc.

(Client and services/supports data capture is envisioned to be achieved through interoperable information systems residing at both the state and local levels. A phased-in approach will be used to achieve this long-term goal of full interoperability.)

Individual Client Outcomes Tracking *(Examples)*

- Initial and periodic assessments
- Ongoing assessments of core outcomes. The following are examples

Recovery & Wellness Oriented Client Outcome Indicators : (These are examples; indicators and measures to be determined though stakeholder and committee recommendations.) Hopefulness Wellness Empowerment Self-efficacy, Etc…	Housing	Functioning
	Criminal justice system involvement	Substance Abuse
	Employment / Education	Quality of Life
	Hospitalization (acute//long term restrictive levels of care)	Illness self-management
		Culture-specific indicators
	Income / Entitlements	Social / community connectedness
	Family preservation	Individual service plan goals
	Symptoms / Suffering	Physical health
	Suicide	Etc.

(State and local information systems interoperability, based on statewide standards, will be the mechanism by which this client outcome information is captured. DMH will work with counties/providers to provide flexible system options with regard to measurement of outcome indicators.)

PERFORMANCE MEASUREMENT

MENTAL HEALTH SYSTEM ACCOUNTABILITY LEVEL

(Evaluation of Community Integrated Services and Supports – *Program/System-Based Measurement*)

Monitoring / Quality Assurance / Oversight *(multi-stakeholder process)* ***(Examples)***

Local / county plans and performance with respect to:

- Cultural competency / no disparities
- Recovery / Resilience philosophy and promotion
- Full participation of clients / family members in service delivery system processes
- Fidelity to evidence-based practice guidelines or model programs
- Adherence to budget / timelines
- Staff / provider competencies
- Adherence to appropriate client-to-staff ratios
- Quality (performance) improvement projects
- Service partnerships - Comprehensive / inter-agency / coordinated service delivery
- Supportive services (e.g., housing, employment, peer-delivered supportive services)
- Coordinated services for co-occurring disorders
- Costs, cost-effectiveness of services
- Etc.

(Measured with standardized review criteria, monitoring tools, electronic data entry / reporting interfaces, etc. Cost information to be associated with client, service, and outcomes tracking information to determine costs per client, cost-effectiveness and cost-benefit analyses of programs, etc.)

Client / Family Satisfaction / Evaluation of Services and Supports *(Examples)*

- Mental Health Statistics Improvement Program (MHSIP) indicators and surveys
- Surveys / assessments targeting specific services / supports appraisal by clients / families / caregivers
- Focus groups / multiple means of eliciting client / family / caregiver input
- Etc.

Staff / Provider Evaluation / Satisfaction with regard to mental health system *(Examples)*

- Perceived effectiveness of the structure of system, inter-agency issues, effectiveness of service models, etc.
  - Interviews / surveys/ focus groups
- Etc.

PERFORMANCE MEASUREMENT

PUBLIC / COMMUNITY- IMPACT LEVEL

(Evaluation of Global Impacts and Community-Focused Strategies)

Mental Health Promotion and Awareness *(Examples)*

- Outreach services (e.g., homeless, rural communities, ethnic/culture-specific outreach, Tele-health, etc.)
- Community Emergency Response Team Services
- Community Mental Health / Depression Screenings
- Educational Seminars (e.g., general public, primary care settings, schools, etc.)
- Anti-Stigma and Anti-Discrimination Campaigns
- Prevention and Early Intervention Efforts
- Workforce Recruitment and Development (e.g., university, licensing board collaborations, continuing education)
- Community Support Groups
- Media, public awareness announcements, (e.g., Recovery & Resiliency)
- Access and educational enhancements (e.g., Network of Care website, promotion of recovery philosophy)
- Etc

(Typically measured by counts of individuals reached, screened, informed, etc.)

Mental Health System Structure / Capacity in Community *(Examples)*

- Inventory of available services & supports (includes cultural competency and language proficiency)
- Location of services, including inter-agency, outreach, mobile, natural/community setting, etc (e.g., GIS mapping)
- Etc.

Community Reaction / Evaluation / Satisfaction with regard to mental health system *(Examples)*

- Media reviews
- Interviews with public officials
- Assessment of community members
- Etc.

Large-Scale Community Indicators *(Examples)*

- Population prevalence of mental illness
- Community mental health need / unmet need
- Percents of youth in juvenile justice or Level12-14 group home placements
- Etc.

Process of Performance Indicator Development for the Mental Health Services Act

Influential Factors and Contributors

- Accountability/Responsibility and Quality Improvement Philosophies

ACCOUNTABILITY

One component of accountability is the effectiveness of services, supports and activities as measured by ***individual client outcomes and community impact.***

The other component is the demonstration that the mental health system is *performing appropriately* in providing services, supports, and activities - that is, ***doing what it should do & said it would do.***

These are the two "arms of accountability":

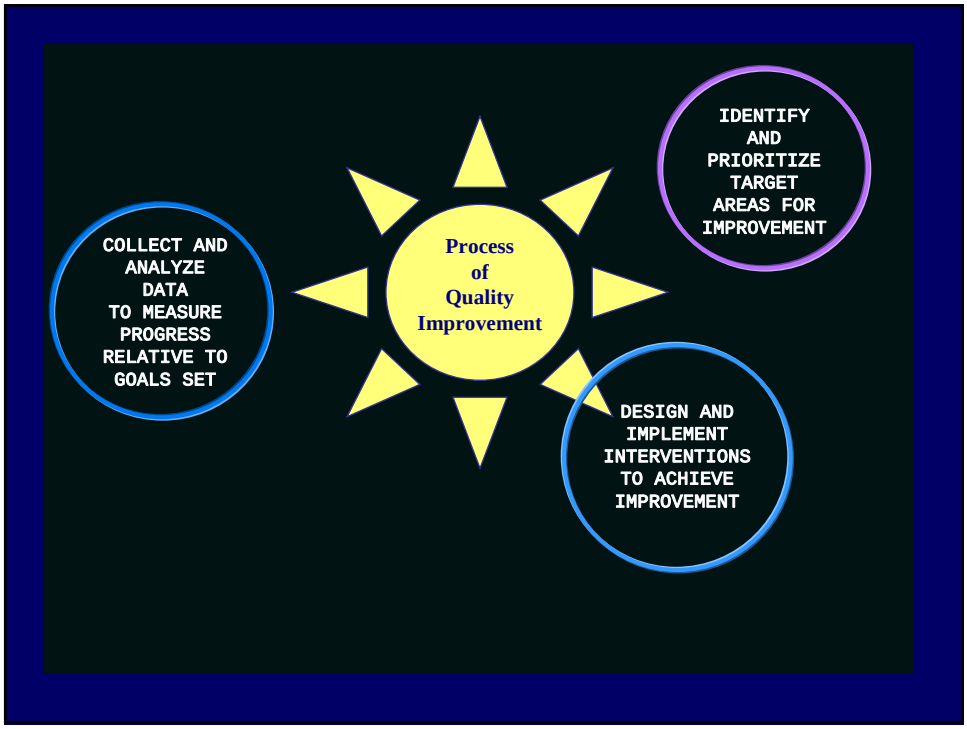
- They make MHSA transformational processes transparent to stakeholders
- They demonstrate that the mental health system is reaching out to both individuals and the community in ways that produce positive results.
- They must both be accomplished without disparities.

RESPONSIBILITY

Mental Health System Responsibilities:*

- **reduce stigma**
- **increase knowledge & understanding of mental health**
- **provide consumer and family driven care**
- **deliver care without disparities**
- **provide early screenings, assessments & referrals**
- **use modern, science-based mental health care**
- **accelerate research & its application to services**
- **use modern technologies**

*Identified by President's New Freedom Commission on Mental Health (2003).



Process of Performance Indicator Development for the Mental Health Services Act

Influential Factors and Contributors

- Large stakeholder process/input & previous legislation
  - Performance Measures (April – June 2005, ongoing)

Outcomes & Performance Indicators

Specific outcome and performance areas have been identified by recent and previous stakeholder input processes:

▪ *Recovery and wellness*	▪ *Substance use*
▪ *Housing*	▪ *Quality of life*
▪ *Criminal and/or juvenile justice system involvement*	▪ *Illness self-management*
▪ *Employment/education*	▪ *Social/community connectedness*
▪ *Hospitalization (acute/long term restrictive levels of care)*	▪ *Individualized service plan goals*
▪ *Income/entitlements*	▪ *Physical health*
▪ *Family preservation*	▪ *Out-of-home placement*
▪ *Symptoms/suffering*	▪ *Non-public school placement*
▪ *Suicide*	▪ *Graduation rates for children/youth diagnosed with serious emotional disorders*
▪ *Cultural/Ethnic/Racial-specific indicators*	
▪ *Functioning*	▪ *Child welfare status*

Process of Performance Indicator Development for the Mental Health Services Act

Influential Factors and Contributors

- AB 2034 as one Model

MHSA Cites AB 34 / 2034 as A Positive Model

- Cites AB 34 and subsequent legislation (AB 2034) as “A model program”
- President’s New Freedom Commission hailed AB 2034 as a model program
- “By expanding programs that have demonstrated their effectiveness, California can save lives and money”

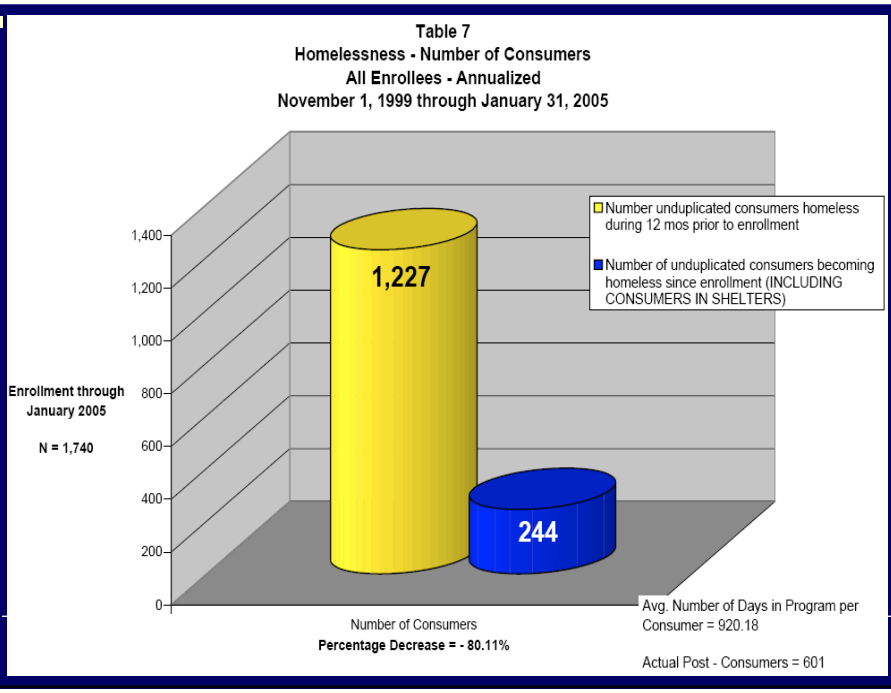
AB 34/2034 Outcomes

HOSPITALIZATION
- Number of Consumers Hospitalized Pre- and Post-enrollment
- Number of Hospitalizations Pre- and Post-enrollment
- Number of Hospital Days Pre- and Post-enrollment

INCARCERATION
- Number of Consumers Incarcerated Pre- and Post-enrollment
- Number of Incarcerations Pre- and Post-enrollment
- Number of Incarceration Days Pre- and Post-enrollment

HOMELESSNESS
- Number of Consumers Homeless Pre- and Post-enrollment
- Number of Homelessness Episodes Pre- and Post-enrollment
- Number of Homeless Days Pre- and Post-enrollment

EMPLOYMENT
- Number of Consumers Employed Pre- and Post-enrollment
- Number of Employment Days Pre- and Post-enrollment



Process of Performance Indicator Development for the Mental Health Services Act

Influential Factors and Contributors

Performance Measurement Advisory Committee (PMAC)

Composition of the Performance Measurement Advisory Committee

The goal of the Department of Mental Health is to maintain a diverse committee with relatively equal representation of the regions of California and the specific skills and areas of expertise listed below:

- Consumer perspective
- Family member perspective
- Small county perspective/expertise
- Large county perspective/expertise
- Rural county perspective/expertise
- Urban county perspective/expertise
- Child/youth perspective/expertise
- Transition-age youth perspective/expertise
- Adult perspective/expertise
- Older adult perspective/expertise
- Research/evaluation/measurement expertise
- Cultural competence expertise
- Mental health management/ supervisory experience
- Expertise in Recovery/Wellness philosophy/orientation
- Mental health services delivery/ clinical experience

Note: There are 4 persons not reflected on the map who represent California organizations that are not county or region specific.

www.dmh.ca.gov/MHSA/PMAC.asp

PMAC Focus and Responsibilities

Review relevant measures and measurement requirements for inclusion:

- MHSA performance measurement requirements and stakeholder input
- National quality strategies and frameworks (e.g., IOM Crossing the Quality Chasm Series, Pres. New Freedom Commission report, etc.)
- Federal initiatives and requirements (e.g. DS2000+, MHSIP, URS, etc.)
- CA initiatives and requirements (e.g. Realignment Legislation, Medi-Cal and HIPAA, CSI, etc.)

PMAC Focus and Responsibilities (cont'd)

Recommend measures based upon:

- meaningfulness, feasibility, measurability
- transformational, recovery and wellness missions of the MHSA
- ability to determine state and system-wide accountability
- other accountability and quality improvement needs
- minimized duplication of data collection efforts

PMAC Focus and Responsibilities (cont'd)

Recommend methods of administering the measures and capturing, analyzing and reporting the data based upon:

- best available information technology options
- efficiencies that minimize administrative burden
- effectiveness that maximizes the usefulness of resulting data

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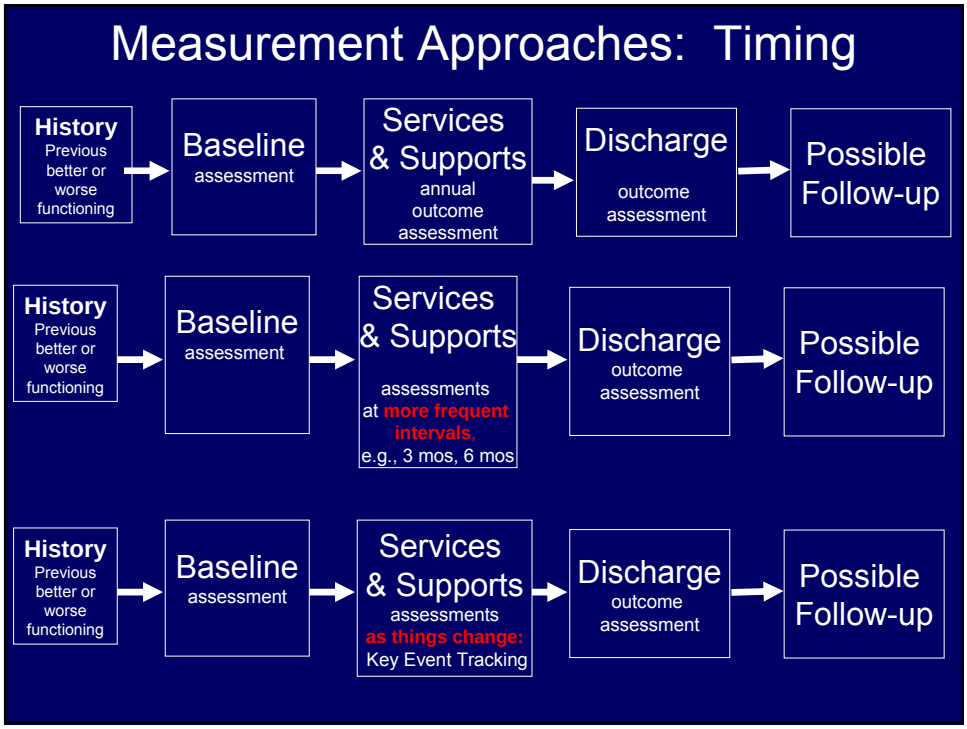
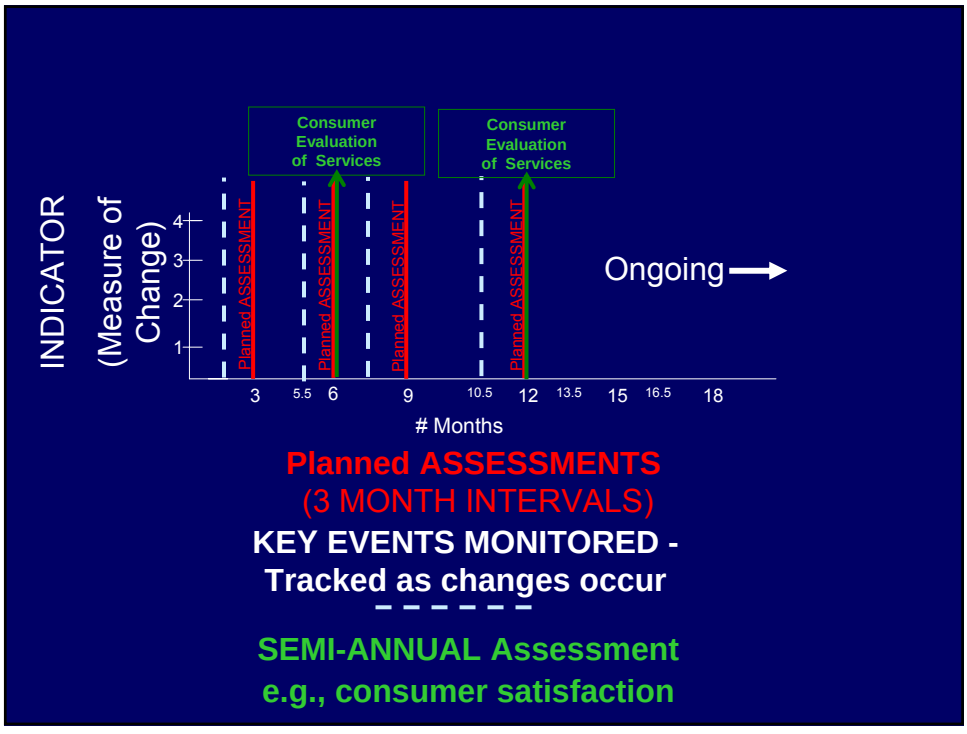
Influential Factors and Contributors

- Appropriate Evaluation Methods

Measurement Approaches: Timing





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Influential Factors and Contributors

- Mental Health Services Oversight and Accountability Commission
- California Mental Health Planning Council
- California Mental Health Directors Association
- State Quality Improvement Council
- Cultural Competence/Ethnic Services Managers
- Etc.

Process of Performance Indicator Development for the Mental Health Services Act

Influential Factors and Contributors

- Federal Requirements
  (URS/DIG, Block Grant, NOMS)

Federal Requirements

- Impact on Client and Information System (CSI)
  e.g.,
  - Race/ethnicity reporting conform to U.S. Census
  - Evidence-based practices reporting
  - Diagnosis reporting (enhanced)
  - Etc.
- MHSIP Consumer Survey
- Block Grant Criteria, Objectives, Transformational Goals

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMS)

www.SAMHSA.gov

DOMAIN	OUTCOME	MEASURES		
		Treatment		Prevention
		Mental Health	Substance Abuse	Substance Abuse
Abstinence	Abstinence from Drug/ Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30-day substance use (non-use/reduction in use) ▶ Perceived risk of use ▶ Age at first use ▶ Perception of disapproval
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/ Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	ATOD suspensions and expulsions; workplace AOD use and perception of workplace policy
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ▶	Drug-related crime; alcohol-related car crashes and injuries
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE

ETC.…

Process of Performance Indicator Development for the Mental Health Services Act

Influential Factors and Contributors

Tracking of MHSA Services, Strategies, and Implementation

- CSI Data Collection
- Cost Reporting & Expenditure Accounting
- Fidelity and Progress Oversight

Tacking of MHSA Strategies, Services & Supports and Implementation

Services And Supports To Individuals
- Service Strategies
- Place of Service
- History of Trauma
- Special Population

→ Client and Services Information System (CSI)

Strategies Not Tied To Individuals (*e.g., planning, health promotion, housing)*

→ Cost report and program-level accounting of expenditures in relation to allocation *(format currently being developed)*

Oversight with regard to Fidelity and Progress

→ Monitoring, on-site review process

Process of Performance Indicator Development for the Mental Health Services Act

Influential Factors and Contributors

- Supporting IT Infrastructure for Performance Measurement and Implementation of IT Vision
- IT Workgroup
  - Performance measures selection now involves the consideration of technology options available to improve the workflow process, data quality, and the feasibility of data collection.

MHSA IT Workgroup

(October, 2005 – present/ongoing)

The MHSA IT Workgroup is comprised of representatives from the following:

- **Mental health services (MHS) consumers and family members**
- **Organizations representing MHS consumers and family members**
- **Mental health services providers**
- **California counties - small, medium and large**
- **Currently contracted county IT vendors**
- **California Department of Mental Health**

MHSA IT Vision

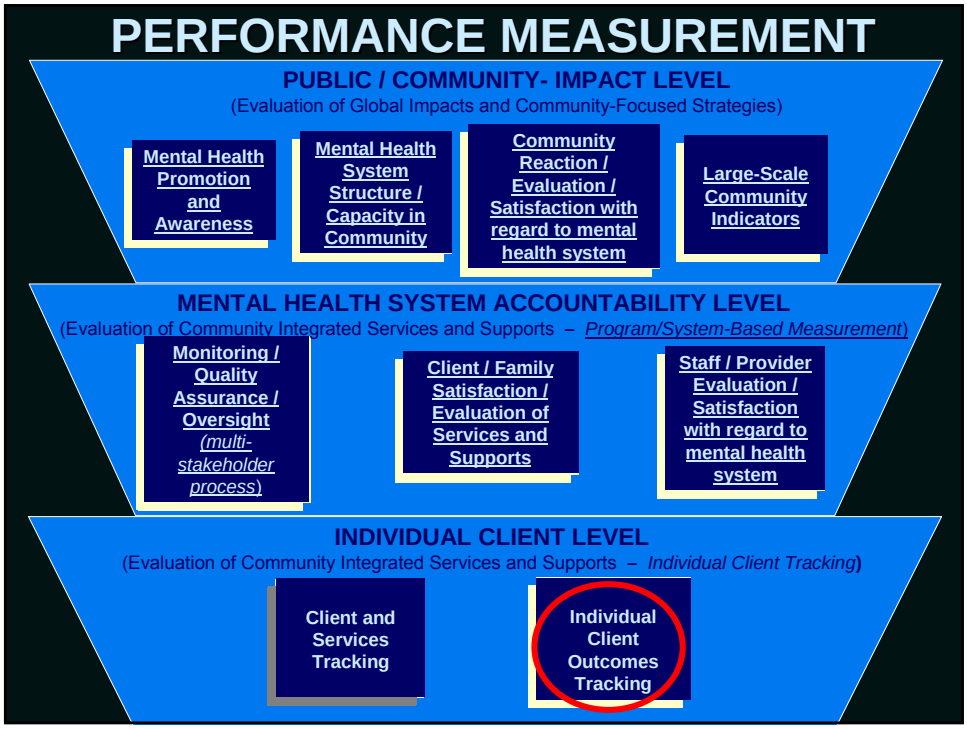
The Transformational Goals of the MHSA Require

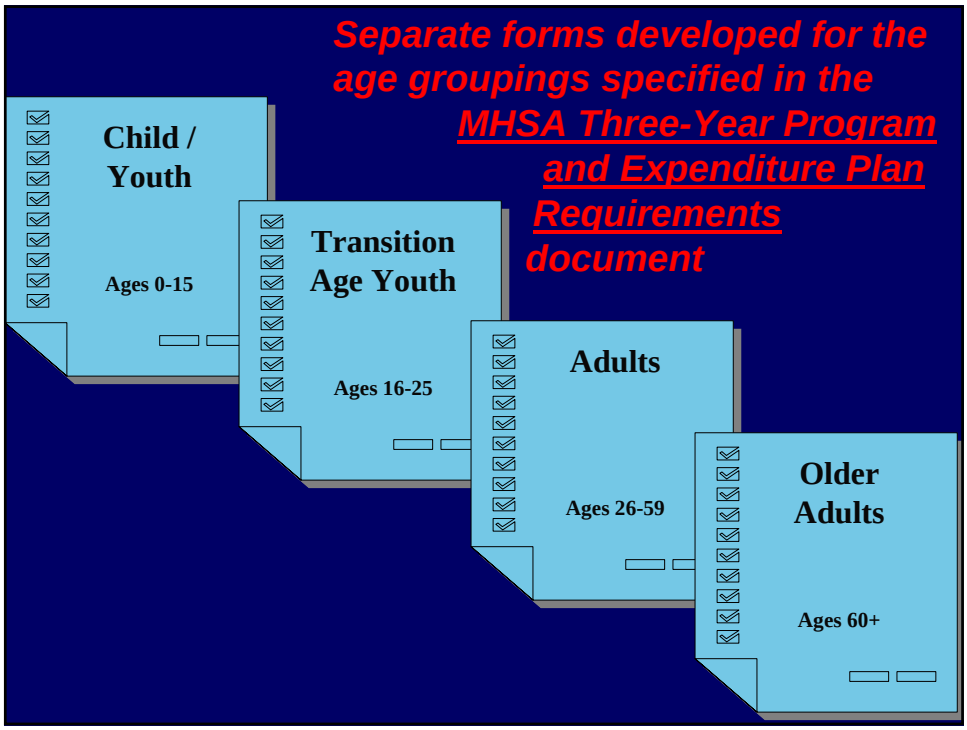
- **A comprehensive mental health IT infrastructure**
- **Widespread adoption of data standards**
- **IT development through multi-stakeholder participation**

First step: **Data Collection and Reporting System (DCR) for Full Service Partnership Outcomes Tracking**

Initial Evaluation of MHSA Full Service Partnership Clients

Methodology and Data Collection/Reporting Options


PERFORMANCE MEASUREMENT
PUBLIC / COMMUNITY- IMPACT LEVEL
(Evaluation of Global Impacts and Community-Focused Strategies)
Mental Health Promotion and Awareness
Mental Health System Structure / Capacity in Community
Community Reaction / Evaluation / Satisfaction with regard to mental health system
Large-Scale Community Indicators
MENTAL HEALTH SYSTEM ACCOUNTABILITY LEVEL
(Evaluation of Community Integrated Services and Supports – Program/System-Based Measurement)
Monitoring / Quality Assurance / Oversight (multi-stakeholder process)
Client / Family Satisfaction / Evaluation of Services and Supports
Staff / Provider Evaluation / Satisfaction with regard to mental health system
INDIVIDUAL CLIENT LEVEL
(Evaluation of Community Integrated Services and Supports – Individual Client Tracking)
Client and Services Tracking
Individual Client Outcomes Tracking


Separate forms developed for the age groupings specified in the MHSA Three-Year Program and Expenditure Plan Requirements document
Child / Youth
Ages 0-15
Transition Age Youth
Ages 16-25
Adults
Ages 26-59
Older Adults
Ages 60+

MHSA FULL SERVICE PARTNERSHIP FORMS

The forms will gather:

History/Baseline data:

Partnership Assessment Form (PAF) –

Completed ONCE, when partnership is established

Follow-Up data:

Key Event Tracking Form (KET) –

Completed when change occurs in key areas

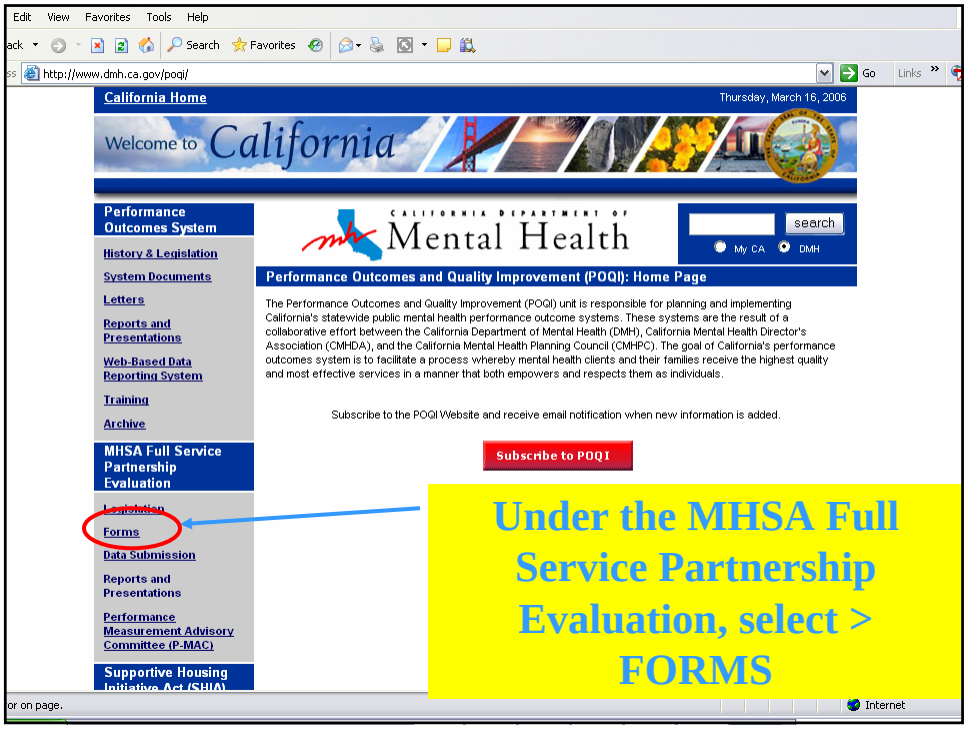
Quarterly Assessment (3M) –

Completed every 3 months

FORM DOMAINS

Partnership Assessment Form (PAF)	Key Event Tracking (KET)	Quarterly Assessment (3M)
Administrative Information	Administrative Information	Administrative Information
Residential (includes hospitalization & incarceration)	Residential (includes hospitalization & incarceration)	
Education	Education	Education
Employment	Employment	
Sources of Financial Support		Sources of Financial Support
Legal Issues / Designations	Legal Issues / Designations	Legal Issues / Designations
Emergency Intervention	Emergency Intervention	
Health Status		Health Status
Substance Abuse		Substance Abuse
ADL / IADL - *Older Adults Only*		ADL / IADL - *Older Adults Only*

Accessing the MHSA Full Service Partnership Outcomes Assessment Forms


California Home
Thursday, March 16, 2006
Welcome to California
Performance Outcomes System
History & Legislation
System Documents
Letters
Reports and Presentations
Web-Based Data Reporting System
Training
Archive
MHSA Full Service Partnership Evaluation
Forms
Data Submission
Reports and Presentations
Performance Measurement Advisory Committee (P-MAC)
Supportive Housing
California Department of Mental Health
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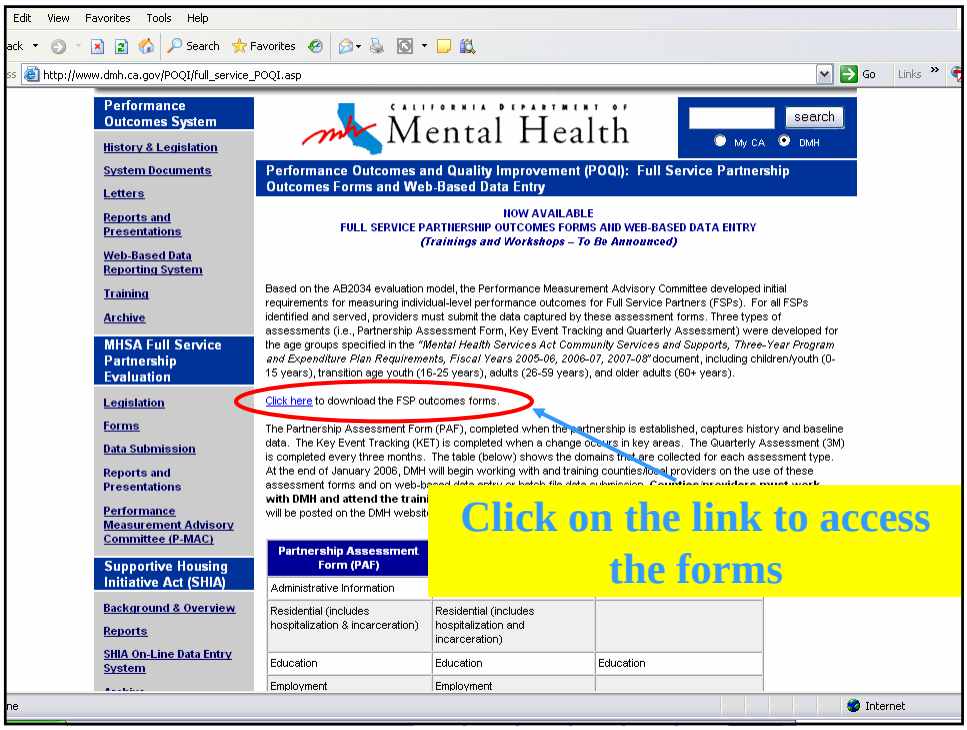
My CA
DMH
Performance Outcomes and Quality Improvement (POQI): Home Page
The Performance Outcomes and Quality Improvement (POQI) unit is responsible for planning and implementing California's statewide public mental health performance outcome systems. These systems are the result of a collaborative effort between the California Department of Mental Health (DMH), California Mental Health Director's Association (CMHDA), and the California Mental Health Planning Council (CMHPC). The goal of California's performance outcomes system is to facilitate a process whereby mental health clients and their families receive the highest quality and most effective services in a manner that both empowers and respects them as individuals.
Subscribe to the POQI Website and receive email notification when new information is added.
Subscribe to POQI
Under the MHSA Full Service Partnership Evaluation, select > FORMS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Performance Measurement Advisory Committee (P-MAC)
Supportive Housing Initiative Act (SHIA)
Background & Overview
Reports
SHIA On-Line Data Entry System
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Performance Outcomes and Quality Improvement (POQI): Full Service Partnership Outcomes Forms and Web-Based Data Entry
NOW AVAILABLE
FULL SERVICE PARTNERSHIP OUTCOMES FORMS AND WEB-BASED DATA ENTRY
(Trainings and Workshops – To Be Announced)
Based on the AB2034 evaluation model, the Performance Measurement Advisory Committee developed initial requirements for measuring individual-level performance outcomes for Full Service Partners (FSPs). For all FSPs identified and served, providers must submit the data captured by these assessment forms. Three types of assessments (i.e., Partnership Assessment Form, Key Event Tracking and Quarterly Assessment) were developed for the age groups specified in the "Mental Health Services Act Community Services and Supports, Three-Year Program and Expenditure Plan Requirements, Fiscal Years 2005-06, 2006-07, 2007-08" document, including children/youth (0-15 years), transition age youth (16-25 years), adults (26-59 years), and older adults (60+ years).
Click here to download the FSP outcomes forms.
The Partnership Assessment Form (PAF), completed when the partnership is established, captures history and baseline data. The Key Event Tracking (KET) is completed when a change occurs in key areas. The Quarterly Assessment (3M) is completed every three months. The table (below) shows the domains that are collected for each assessment type.
Partnership Assessment Form (PAF)
Administrative Information
Residential (includes hospitalization & incarceration)
Residential (includes hospitalization and incarceration)
Education
Education
Education
Employment
Employment
Click on the link to access the forms

MHSA FSP Training

Counties must receive *Full Service Partnership Outcomes Assessment* training in order to become "certified" to collect Full Service Partnership data and use the DCR System.

Counties should contact the DMH POQI Unit to schedule training.

Options for Collecting & Reporting FSP Data to DMH

Getting Data to DMH

Option 1: DMH On-Line Data Collection & Reporting (DCR) System

County submits data directly to DMH using a DMH designed on-line, key-entry system. **DMH maintains the data system** and makes all updates.

Option 2: Local System Data Reporting

County collects data using their own technology. County submits data via XML (Extensible Markup Language). **County is responsible for maintaining their own data system and making all updates.**

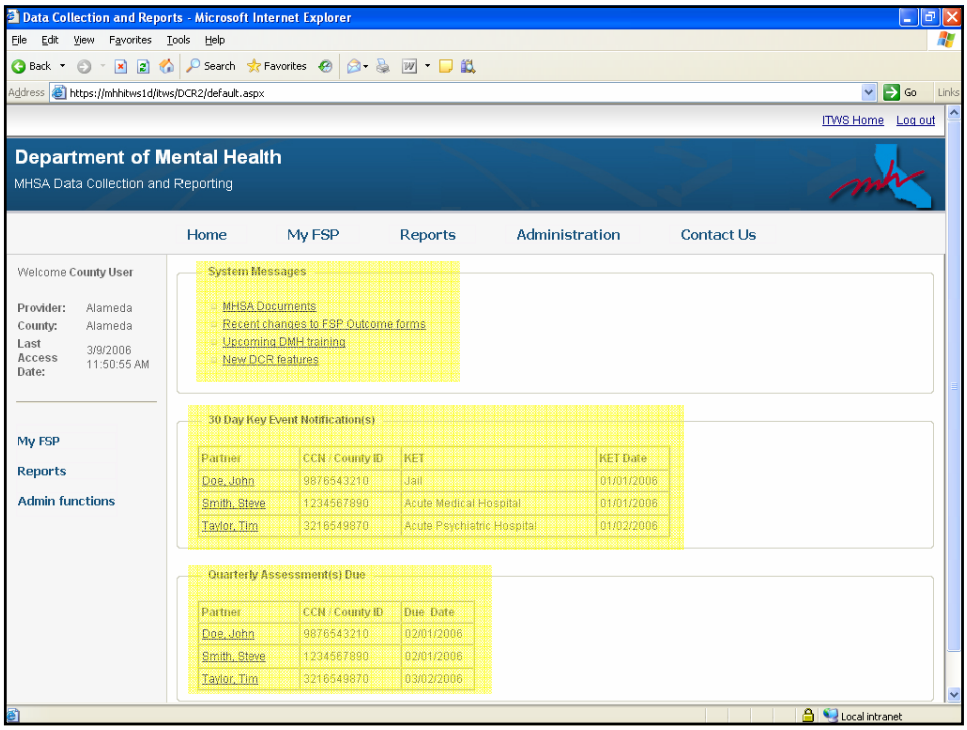
Option 1: DMH DCR

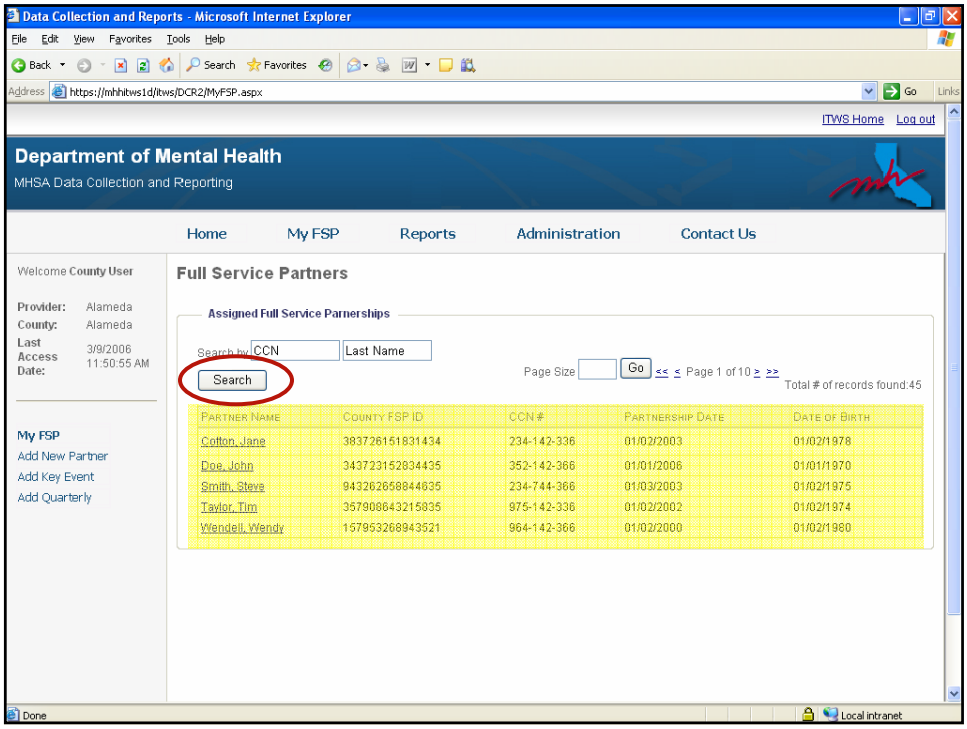
Phase 1: Available January 1, 2006

- **Allows data submission and batched data return**
- **Provides basic HTML interface with some error checking and validation functionality**

Phase 2: Available Summer 2006

- **Allows editing of submitted data**
- **Allows query and reporting capability**
- **Performs County Client Number verification against CSI data**
- **Provides real time data download capability**
- **Performs stringent data validations during data entry**
- **Provides user friendly interface**
- **Allows XML schema based integration**
- **Provides "tickler" mechanism to track when reviews/assessments are due**





Option 2: XML Data Submission

- Counties are responsible for ensuring that the most recent version of the DMH XML Schema Definition (XSD) is used to submit data
- Current versions of the XSD can be downloaded by authorized users from the DMH ITWS at https://mhhitws.cahwnet.gov/
- DMH will work with counties on data submission timeframe.
- Ideally, data collected locally will be submitted to DMH on a nightly basis.

DMH Performance Outcomes & Quality Improvement

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